STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154057	A. BUILDING **01 - OPTIONS HOSPITAL** B. WING _____	R **06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIONS BEHAVIORAL HEALTH SYSTEM	**5602 CAITO DRIVE** **INDIANAPOLIS, IN 46226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 02/05/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 06/04/15 Facility Number: 012773 Provider Number: 154057 AIM Number: NA At this PSR survey, Options Behavioral Health System was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. This facility, located on the first floor of a two story building, was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detectors in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all patient sleeping rooms. The facility has a capacity of 40 and had a census of 25 at the time of this survey. All areas where patients have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has elected to utilize a Categorical Waiver pertaining to door locking arrangements where the clinical needs of the patients require	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 specialized security measures for their safety.	{K 000}		